

Please Print Legibly or Type

IDENTIFIABLE DATA ORDER FORM ONLY

Centers for Medicare & Medicaid Services
Public Use Files
Accounting Division
P.O. Box 7520
Baltimore, Maryland 21207-0520

Date: _____

PURCHASE REQUEST

	<u>FILE NAMES</u>	<u>YEAR</u>	<u>COST</u>
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____

TOTAL

COMPANY CHECK/MONEY ORDER AMOUNT: Payable to: CMS-PUF

(No Personal Checks. All checks must be drawn on a U.S. bank.)

(No Credit Cards Accepted)

AGENCY LOCATION CODE (U.S. Federal Government)

OUTPUT SPECIFICATIONS:

1. Cartridge (Standard Output)
3490e compressed

2. Cartridge 3480
(Special request only)

3. CD-ROM _____ (Certain files only-check website for media offered)

EXPRESS COMPANY: (i.e., Fed Ex, Airborne, etc.)

EXPRESS ACCOUNT: (Number)

NAME:

TITLE:

COMPANY/ORGANIZATION:

ADDRESS:

CITY/STATE/ZIPCODE:

PHONE
NUMBER:

FAX NUMBER:

SIGNATURE:

Allow 4-6 weeks for delivery.

This form can be reproduced for additional orders.

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